STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010235	A. BUILDING: _____ B. WING _____	R-C 12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00139369. Complaint IN 00139369 Corrected. Survey date: December 12, 2013 Facility number: 010235 Provider number: 010235 AIM number: NA Survey team: Christine Fodrea, RN, TC Census bed type: Residential: 64 Total: 64 Census payor type: Other: 64 Total: 64 Sample: 3 Harbour Assisted Living of Fort Wayne was found top be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint number IN00139369. Quality review completed on December 12, 2013 by Randy Fry RN.	{R 000}		